CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10269	**Date: August 7, 2020**
	Change Request 11880

SUBJECT: Billing for Home Infusion Therapy Services On or After January 1, 2021

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is guidance and claims processing systems changes necessary to implement of Section 5012(d) of the 21st Century Cures Act, and to detail necessary changes to those systems and processes to design business requirements for a future implementation CR. These payments begin January 1, 2021.

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	32/Table of Contents
N	32/411/Home Infusion Therapy Services
N	32/411/411.1/Policy
N	32/411/411.2/Coverage Requirements
N	32/411/411.3/Home Infusion Drugs: Healthcare Common Procedural Coding System (HCPCS) Drug Codes
N	32/411/411.4/Billing and Payment Requirements
N	32/411/411.5/Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Group Codes, and Medicare Summary Notice Messages
N	32/411/411.6/CWF and MCS Editing Requirements

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 10269	Date: August 7, 2020	Change Request: 11880

SUBJECT: Billing for Home Infusion Therapy Services On or After January 1, 2021

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

I. GENERAL INFORMATION

A. Background: Section 5012(d) of the 21st Century Cures Act (Pub. L 144-255) amended sections 1861(s)(2) and 1861(iii) of the Social Security Act (the Act), requiring the Secretary to establish a new Medicare home infusion therapy services benefit. The Medicare home infusion therapy services benefit covers the professional services, including nursing services, furnished in accordance with the plan of care, patient training and education (not otherwise covered under the durable medical equipment benefit), remote monitoring, and monitoring services for the provision of home infusion therapy services and home infusion drugs furnished by a qualified home infusion therapy supplier.

Section 1861(iii)(3)(C) of the Act defines "home infusion drug" as a parenteral drug or biological administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of durable medical equipment (as defined in section 1861(n) of the Act). Such term does not include insulin pump systems or self-administered drugs or biologicals on a self-administered drug exclusion list.

Section 1834(u)(1)(A)(ii) of the Act states that a unit of single payment under this payment system is for each infusion drug administration calendar day in the individual's home, and requires the Secretary, as appropriate, to establish single payment amounts for different types of infusion therapy, taking into account variation in utilization of nursing services by therapy type.

Section 1834(u)(1)(A)(iii) of the Act provides a limitation to the single payment amount, requiring that it shall not exceed the amount determined under the PFS (under section 1848 of the Act) for infusion therapy services furnished in a calendar day if furnished in a physician office setting.

Section 1834(u)(1)(B)(i) of the Act requires that the single payment amount be adjusted to reflect a geographic wage index and other costs that may vary by region. Subparagraphs (A) and (B) of section 1834(u)(3) of the Act specify annual adjustments to the single payment amount that are required to be made beginning January 1, 2022. In accordance with these sections the single payment amount will increase by the percent increase in the Consumer Price Index for all urban consumers (CPI-U) for the 12-month period ending with June of the preceding year, reduced by the 10 year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP).

Section 1834(u)(1)(C) of the Act allows the Secretary discretion to adjust the single payment amount to reflect outlier situations and other factors as the Secretary determines appropriate, in a budget neutral manner.

B. Policy: As described in the 21st Century Cures Act, a separate payment for home infusion therapy services will be made under the permanent home infusion therapy benefit to qualified home infusion suppliers, effective January 1, 2021. Home infusion drugs are assigned to three payment categories, as determined by the HCPCS J-code. Payment category 1 includes certain intravenous antifungals and antivirals, uninterrupted long-term infusions, pain management, inotropic, chelation drugs. Payment category 2 includes subcutaneous immunotherapy and other certain subcutaneous infusion drugs. Payment category 3 includes certain chemotherapy drugs. CMS will continue to use the G-codes, established for the

temporary transitional payments in CYs 2019 and 2020, for the professional services furnished on an infusion drug administration calendar day for each payment category. CMS has established a single payment amount for each of the three categories for professional services furnished for each infusion drug administration calendar day. Each payment category will be paid at amounts in accordance with infusion codes and units for such codes under the physician fee schedule for each infusion drug administration calendar day in the individual's home for drugs assigned to such category. The payment amounts are equal to 5 hours of infusion therapy in a physician's office.

In accordance with section 1834(u)(1)(B)(i) of the Act, we are using the Geographic Adjustment Factor (GAF) to wage adjust the home infusion therapy services payment. In order to make the application of the GAF budget neutral we are going to apply a budget-neutrality factor. Additionally, in CY 2022, we will adjust the single payment amount by the percent increase in the Consumer Price Index for all urban consumers (CPI-U) for the 12-month period ending with June of the preceding year, reduced by the 10 year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP).

Finally, we are increasing the payment amounts for each of the three payment categories for the initial infusion therapy service visit by the relative payment for a new patient rate over an existing patient rate using the physician evaluation and management (E/M) payment amounts for a given year. Overall this adjustment would be budget-neutral, resulting in a small decrease to the payment amounts for any subsequent infusion therapy service visits.

In the event that multiple drugs, which are not all assigned to the same payment category, are administered on the same infusion drug administration calendar day, a single payment would be made that is equal to the highest payment category.

The G-codes are:

- G0068: Professional services for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 minutes Short Descriptor: Adm IV infusion drug in home.

- G0069: Professional services for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes Short Descriptor: Adm SQ infusion drug in home.

- G0070: Professional services for the administration of intravenous chemotherapy or other intravenous highly complex drug or biological infusion for each infusion drug administration calendar day in the individual's home, each 15 minutes. Short Descriptor: Adm of IV chemo drug in home.

- G0088: Professional services, initial visit, for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 minutes. Short Descriptor: Adm IV drug 1st home visit.

- G0089: Professional services, initial visit, for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes. Short Descriptor: Adm SubQ drug 1st home visit.

- G0090: Professional services, initial visit, for the administration of intravenous chemotherapy or other highly complex infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes. Short Descriptor: Adm IV chemo 1st home visit.

NOTE: The G-code payment rates are being added to the PFS fee schedule incorporating the required annual and geographic wage adjustments.

A qualified home infusion therapy supplier is only required to enroll in Medicare as a Part B supplier and is not required to enroll as a DME supplier, therefore, the G-codes will be billed through the A/B MACs and the Multi-Carrier System (MCS) for Medicare Part B claims. DME suppliers, also enrolled as qualified home infusion therapy suppliers, would continue to submit DME claims through the DME MACs; however, they would also be required to submit home infusion therapy service claims (G-codes) to the A/B MACs for processing. The qualified home infusion therapy supplier will submit all home infusion therapy service claims on the 837P/CMS-1500 professional and supplier claims form to the A/B MACs. DME suppliers, concurrently enrolled as qualified home infusion therapy suppliers, will need to submit one claim for the DME, supplies, and drug on the 837P/CMS-1500 professional and supplier claims form to the DME MAC and a separate 837P/CMS-1500 professional and supplier claims form for the professional services to the A/B MAC.

Because the home infusion therapy services are contingent upon a home infusion drug J-code being billed, the appropriate drug associated with the visit must be billed with the visit or no more than 30 days prior to the visit. To identify and process claims for the items and services furnished under the home infusion therapy benefit, a Common Working File (CWF) edit will be implemented for the submitted G-code claims. The claims processing system will recycle the G-code claim for the professional services associated with the administration of the home infusion drug until a claim containing the J-code for the infusion drug is received in the CWF. The professional visit G-code claim will recycle three times (with a 30-day look back period) for a total of 15 business days. After 15 business days, if no J-code claim is found in claims history, the G-code claim will be denied.

Suppliers must ensure that the appropriate drug associated with the visit is billed with no more than 30 days prior to the visit. In the event that multiple visits occur on the same date of service, suppliers must only bill for one visit and should report the highest paying visit with the applicable drug. Claims reporting multiple visits on the same line item date of service will be returned as unprocessable.

Additionally, home infusion therapy suppliers will use a new G-code to differentiate the first visit from all subsequent visits. Home infusion therapy suppliers may only bill the new G-code to indicate an initial visit for a new patient who had previously received their last home infusion therapy service visit more than 60 days prior to the new initial home infusion therapy service visit. If any of the home infusion therapy G-codes is found in the claims history within 60-days prior to the date of service for an initial visit, then the initial visit claim will be rejected.

Suppliers should report visit length in 15-minute increments (15 minutes = 1 unit). See Attachment A for the table of rounding of units, Payment Categories for Home Infusion Therapy Professional Services, and Payment Categories for Home Infusion Drugs.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11880 - 04.1	Contractors shall accept and pay for home infusion therapy services to eligible home infusion suppliers (new specialty **D6**) effective for claim lines with dates of service on or after January 1, 2021.		X							
11880 - 04.1.1	Contractors shall deny claim lines from specialties other than D6 and use the following messages: CARC 16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC N256 - Missing/incomplete/invalid billing provider/supplier name. Group Code: CO. MSN message: 41.14: This service/item was billed incorrectly. 41.14- Este servicio o artículo fue facturado incorrectamente.		X							
11880 - 04.2	Contractors shall accept and manually load the G-codes (in policy section above) for the professional services rendered on an infusion drug administration calendar day for each payment category in Attachment A. **NOTE**: For testing purposes, Contractors shall add the 'G' codes, TOS and descriptors with an effective date of October 1, 2020.		X						X	STC
11880 - 04.2.1	Contractors shall use Type of Service (TOS) Code 1 for all 6 G codes.		X						X	
11880 - 04.3	Contractors shall pay only 1 of the G codes listed above per line item date of service. **NOTE:** • The fees associated with the G codes on the MPFSD fee file will be "a per day rate;"		X						X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	therefore, the units on the line should not be multiplied by the rate. • The drug remains separately payable from the G code line item.									
11880 - 04.3.1	Contractors shall deny the CWF rejected claim if a new G code is received for the same date of service as a previous claim was paid for the same line item date of service. **NOTE:** The provider should submit an adjustment to the original claim to receive the higher payment.		X							
11880 - 04.3.2	Contractors shall use the following CARC/RARC codes when denying claims: CARC 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC N111 - No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated. Claim Adjustment Group Code - CO (Contractual Obligation) MSN message: 41.14: This service/item was billed incorrectly. 41.14- Este servicio o artículo fue facturado incorrectamente.		X							
11880 - 04.3.3	MCS shall create a new edit to identify when there is more than one of the following six HCPCS ‘G0068’, ‘G0069’ ‘G0070’, ‘G0088’, ‘G0089’, or ‘G0090’ with Date of Service on or after 1/1/2021 for the same Date of Service on the same Part B Professional claim.						X			
11880 - 04.4	CWF shall create a new reject when a Part B Professional claim with one of the following six HCPCS ‘G0068’, ‘G0069’ ‘G0070’, ‘G0088’, ‘G0089’, or ‘G0090’ codes with a Date of Service on or after 1/1/2021 and there is no DME claim in history with one of the identified J-codes (see attached A) within 30 days prior to the incoming Date of Service. **NOTE**: This edit shall have override capability at the claim detail line.								X	
11880 - 04.4.1	Contractors shall recycle a claim with ‘G0068’, ‘G0069’ ‘G0070’, ‘G0088’, ‘G0089’, or ‘G0090’ up		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	to three times for a minimum of up to 15 days until a claim containing an allowable drug J-code from Attachment A is received with the same line item date of service or within 30 days prior to the line item date of service of the G-code.									
11880 - 04.4.2	Contractors shall deny the CWF rejected G-code line when the claim has recycled three times without finding the associated drug J-code claim and use the following messages: CARC 16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC N657 - This should be billed with the appropriate code for these services. Claim Adjustment Group Code - CO (Contractual Obligation) MSN message: 41.14: This service/item was billed incorrectly. 41.14- Este servicio o artículo fue facturado incorrectamente.		X							
11880 - 04.5	CWF shall create a new reject when a Part B Professional claim with one of the following six HCPCS ‘G0068’, ‘G0069’ ‘G0070’, ‘G0088’, ‘G0089’, or ‘G0090’ with Date of Service on or after 1/1/2021 when there is a Part B claim in history with one of the identified six HCPCS ‘G0068’, ‘G0069’ ‘G0070’, ‘G0088’, ‘G0089’, or ‘G0090’ codes for the same Date of Service. **NOTE**: This edit shall have override capability at the claim detail line.								X	
11880 - 04.5.1	Contractors shall use the following messaging when denying these claims: CARC 16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC N657 - This should be billed with the appropriate code for these services. Claim Adjustment Group Code - CO (Contractual Obligation) MSN message: 41.14: This service/item was billed incorrectly. 41.14- Este servicio o artículo fue facturado incorrectamente.									
11880 - 04.6	CWF shall create a new reject for a Part B Professional claim with one of the new ‘G0088’, ‘G0089’, or ‘G0090’ codes and in history is an allowed DME or Part B Professional claim with any of the 6 ‘G0068’, ‘G0069’ ‘G0070’, ‘G0088’, ‘G0089’, or ‘G0090’ codes and the Dates of Service is within 60 days prior to the incoming claim’s Dates of Service. The incoming claim has Dates of Service on or after 1/1/2021. **NOTE**: This edit shall have override capability at the claim detail line.								X	
11880 - 04.6.1	CWF should still subject an incoming Part B Professional claim to the edit if it is within 60 days of posted DME claim and if the claim in history is DME and has one of the existing ‘G0068’, ‘G0069’ ‘G0070’ codes and has Dates of Service prior to 1/1/2021.								X	
11880 - 04.6.1.1	Contractors shall deny CWF rejected claims for more than one claim line service of one of the six ‘G0068’, ‘G0069’ ‘G0070’, ‘G0088’, ‘G0089’, or ‘G0090’ with Dates of Service within a 60 day period and use the following messages: CARC 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	RARC N640 - Exceeds number/frequency approved/allowed within time period. Group Code - CO (Contractual Obligation). MSN message: 41.14: This service/item was billed incorrectly. 41.14- Este servicio o artículo fue facturado incorrectamente.									
11880 - 04.6.2	CWF shall create a new Informational Unsolicited Response when a Part B Professional claim or a DME claim with one of the six 'G0068', 'G0069' 'G0070', 'G0088', 'G0089', or 'G0090' codes is received and in history is a Part B Professional claim with one of the three new 'G0088', 'G0089', or 'G0090' codes with Dates of Service within 60 days after the incoming claim's Dates of Service.						X		X	
11880 - 04.7	The Medicare contractor shall ensure that all new edits and the IUR appear on the ORPN Report.								X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11880 - 04.8	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.		X		X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	CR 10836

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cheryl Gilbreath, 410-786-5919 or cheryl.gilbreath@cms.hhs.gov, Yvette Cousar, 410-786-2160 or yvette.cousar@cms.hhs.gov.

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Medicare Claims Processing Manual
Chapter 32 – Billing Requirements for Special Services

Table of Contents
(Rev. 10269, 08-07-2020)

Transmittals for Chapter 32

411– Home Infusion Therapy Services

(Rev. 10269, Issued: 08-07-2020, Effective: 01-01-2021, Implementation: 01-04-2021)

411.1 – Policy

(Rev. 10269, Issued: 08-07-2020, Effective: 01-01-2021, Implementation: 01-04-2021)

Effective beginning on January 1, 2021, the Medicare home infusion therapy benefit covers the professional services, including nursing services, furnished in accordance with the plan of care, patient training and education (not otherwise covered under the durable medical equipment benefit), remote monitoring, and monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. Home infusion therapy means the items and services furnished by a qualified home infusion therapy supplier, which are furnished in the individual's home. Payment is for an "infusion drug administration calendar day," which means the day on which home infusion therapy services are furnished by skilled professionals in the individual's home on the day of infusion drug administration. The skilled services provided on such day must be so inherently complex that they can only be safely and effectively performed by, or under the supervision of, professional or technical personnel.

411.2 – Coverage Requirements

(Rev. 10269, Issued: 08-07-2020, Effective: 01-01-2021 Implementation: 01-04-2021)

Payment for an "infusion drug administration calendar day" is only made if a beneficiary is furnished certain drugs and biologicals administered through an item of covered DME, and payable only to suppliers enrolled in Medicare as a "qualified home infusion therapy supplier." The beneficiary must be under the care of an applicable provider, defined as a physician, nurse practitioner, or physician's assistant, and must be under the care of a physician-established plan of care that prescribes the type, amount, and duration of infusion therapy services. A "qualified home infusion therapy supplier" is a pharmacy, physician, or other provider of services or supplier licensed by the state in which supplies or services are furnished. Qualified home infusion therapy suppliers must furnish infusion therapy to individuals with acute or chronic conditions requiring administration of home infusion drugs; ensure the safe and effective provision and administration of home infusion therapy on a 7-day-a-week, 24-hour-a-day basis; and be accredited by an organization designated by the Secretary. The supplier may subcontract with a pharmacy, physician, other qualified supplier or provider of services in order to meet these requirements.

411.3 - Home Infusion Drugs: Healthcare Common Procedural Coding System (HCPCS) Drug Codes

(Rev. 10269, Issued: 08-07-2020, Effective: 01-01-2021, Implementation: 01-04-2021.)

The home infusion therapy services payment is intended to cover the professional services needed for the administration of certain home infusion drugs covered as supplies necessary for the effective use of external infusion pumps. This payment separately and explicitly pays for the services related to the administration of the drugs identified on the DME LCD for External Infusion Pumps, when such services are furnished in the individual's home. Section 1861(iii)(3)(C) of the Act defines "home infusion drug" as a parenteral drug or biological administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of durable medical equipment (as defined in section 1861(n) of the Act). Such term does not include insulin pump systems or self-administered drugs or biologicals on a self-administered drug exclusion list.

Home infusion drugs are assigned to three payment categories, as determined by the HCPCS J-code. Payment category 1 includes certain intravenous antifungals and antivirals, uninterrupted long-term infusions, pain management, inotropic, chelation drugs. Payment category 2 includes subcutaneous immunotherapy and other certain subcutaneous infusion drugs. Payment category 3 includes certain chemotherapy drugs. CMS will continue to use the G-codes, established for the temporary transitional payments in CYs 2019 and 2020, for the professional services furnished on an infusion drug administration calendar day for each payment category. CMS has established a single payment amount for each of the

three categories for professional services furnished for each infusion drug administration calendar day. Each payment category will be paid at amounts in accordance with infusion codes and units for such codes under the physician fee schedule for each infusion drug administration calendar day in the individual's home for drugs assigned to such category. The payment amounts are equal to 5 hours of infusion therapy in a physician's office. Further policy information can be found in Publication 100-02, Chapter 15, Section 320.

Category 1	
J-Code	*Description*
J0133	*Injection, acyclovir, 5 mg*
J0285	*Injection, amphotericin b, 50 mg*
J0287	*Injection, amphotericin b lipid complex, 10 mg*
J0288	*Injection, amphotericin b cholesteryl sulfate complex, 10 mg*
J0289	*Injection, amphotericin b liposome, 10 mg*
J0895	*Injection, deferoxamine mesylate, 500 mg*
J1170	*Injection, hydromorphone, up to 4 mg*
J1250	*Injection, dobutamine hydrochloride, per 250 mg*
J1265	*Injection, dopamine hcl, 40 mg*
J1325	*Injection, epoprostenol, 0.5 mg*
J1455	*Injection, foscarnet sodium, per 1000 mg*
J1457	*Injection, gallium nitrate, 1 mg*
J1570	*Injection, ganciclovir sodium, 500 mg*
J2175	*Injection, meperidine hydrochloride, per 100 mg*
J2260	*Injection, milrinone lactate, 5 mg*
J2270	*Injection, morphine sulfate, up to 10 mg*
J3010	*Injection, fentanyl citrate, 0.1 mg*
J3285	*Injection, treprostinil, 1 mg*
Category 2	
J-Code	*Description*
J1555 JB	*Injection, immune globulin (cuvitru), 100 mg*
J1558 JB	*Injection, immune globulin (xembify), 100mg*
J1561 JB	*Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g. liquid), 500 mg*
J1562 JB	*Injection, immune globulin (vivaglobin), 100 mg*
J1569 JB	*Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg*
J1575 JB	*Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immune globulin*
Category 3	
J-Code	*Description*
J9000	*Injection, doxorubicin hydrochloride, 10 mg*
J9039	*Injection, blinatumomab, 1 microgram*
J9040	*Injection, bleomycin sulfate, 15 units*
J9065	*Injection, cladribine, per 1 mg*
J9100	*Injection, cytarabine, 100 mg*
J9190	*Injection, fluorouracil, 500 mg*
J9360	*Injection, vinblastine sulfate, 1 mg*
J9370	*Injection, vincristine sulfate, 1 mg*

It is important to note that this list is not static. The payment category may be determined by the contractor for any new home infusion drug additions to the Local Coverage Determination (LCD) for External Infusion Pumps as identified by the following not-otherwise-classified (NOC) codes:

J7799 - Not otherwise classified drugs, other than inhalation drugs, administered through DME
J7999 - Compounded drug, not otherwise classified.

411.4 - Billing and Payment Requirements

(Rev. 10269, Issued: 08-07-2020, Effective: 01-01-2021, Implementation: 01-04-2021)

*Contractors shall accept and pay for home infusion therapy services to eligible home infusion therapy suppliers (new specialty **D6**) effective for claim lines with dates of service on or after January 1, 2021 using the one of the following 'G' codes and applicable 'J' codes listed in section 411.3 of this chapter. Claims for the home infusion therapy service G-codes are billed to the A/B MACs and are payable to home infusion therapy suppliers; this service is no longer payable to DME suppliers. The applicable 'J' codes are billed to the DME MACs by the DME supplier.*

Contractors shall use Type of Service (TOS) Code 1 for all six G-codes. Contractors shall pay only one of the G-codes per line item date of service when one of the drugs from the applicable category is billed with the same line item date of service or a date of service within 30 days prior to the G-code visit.

NOTE:

- *The fees associated with the G-codes on the MPFSD fee file will be "a per day rate;" therefore, the units on the line should not be multiplied by the rate.*
  The drug remains separately payable from the G-code line item

Home infusion therapy suppliers will report the following HCPCS G-codes associated with the payment categories for the professional services furnished in the individual's home and on an infusion drug administration calendar day.

Because the home infusion therapy services are contingent upon a home infusion drug J-code, home infusion therapy suppliers must ensure that the appropriate drug associated with the visit is billed no more than 30 days prior to the visit. In the event that multiple visits occur on the same date of service, or multiple drugs, which are not all assigned to the same payment category, are administered on the same infusion drug administration calendar day, a single payment would be made that is equal to the highest payment category. Suppliers must only bill for one visit and should report the highest paying visit with the applicable drug.

To differentiate the first visit from all subsequent visits, home infusion therapy suppliers may only bill one of the "initial visit" G-codes to indicate an visit for a new patient who had previously received their last home infusion therapy service visit more than 60 days prior to the new initial home infusion therapy service visit.

Home infusion therapy suppliers should report visit length in 15-minute increments (15 minutes=1 unit). See the Table 1 below for the rounding of units.

Table 1: Time Increments

Unit	*Time*
1	*<23 minutes*
2	*= 23 minutes to <38 minutes*
3	*= 38 minutes to <53 minutes*
4	*= 53 minutes to <68 minutes*
5	*= 68 minutes to <83 minutes*
6	*= 83 minutes to <98 minutes*
7	*= 98 minutes to <113 minutes*
8	*= 113 minutes to <128 minutes*
9	*= 128 minutes to <143 minutes*
10	*= 143 minutes to <158 minutes*

Table 2 shows the use of the G-codes established for the home infusion therapy benefit, and reflects the therapy type and complexity of the drug administration.

Table 2: Payment Categories for Home Infusion Therapy Professional Services (G-Codes)

	Category 1	***Category 2***	***Category 3***
Description ***G-Code***	*Intravenous anti-infective, pain management, chelation, pulmonary hypertension, inotropic, and other certain intravenous infusion drugs*	*Subcutaneous immunotherapy and other certain Subcutaneous infusion drugs*	*Chemotherapy and other certain highly complex intravenous drugs*
Initial Visit	*G0088*	*G0089*	*G0090*
Subsequent Visit	*G0068*	*G0069*	*G0070*

- ***G0068:*** *Professional services for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 minutes*

  Short Descriptor: Adm IV infusion drug in home

- ***G0069:*** *Professional services for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes*

  Short Descriptor: Adm SQ infusion drug in home

- ***G0070:*** *Professional services for the administration of intravenous chemotherapy or other intravenous highly complex drug or biological infusion for each infusion drug administration calendar day in the individual's home, each 15 minutes.*

  Short Descriptor: Adm of IV chemo drug in home

- ***G0088:*** *Professional services, initial visit, for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 minutes.*

Short Descriptor: Adm IV drug 1st home visit

- ***G0089:*** *Professional services, initial visit, for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes.*

  Short Descriptor: Adm SubQ drug 1st home visit

- ***G0090:*** *Professional services, initial visit, for the administration of intravenous chemotherapy or other highly complex infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes.*

  Short Descriptor: Adm IV chemo 1st home visit

411.5 – Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Group Codes, and Medicare Summary Notice Messages
(Rev. 10269, Issued: 08-07-2020, Effective: 01-01-2021, Implementation: 01-04-2021)

Contractors shall deny the CWF rejected claim if a new G-code is received for the same date of service as a previous claim was paid for the same line item date of service.

NOTE: *The provider should submit an adjustment to the original claim to receive the higher payment.*

Contractors shall use the following CARC/RARC codes when denying claims:

CARC 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N111 - No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.

Claim Adjustment Group Code - CO (Contractual Obligation)

MSN message: 41.14: This service/item was billed incorrectly. 41.14- Este servicio o artículo fue facturado incorrectamente.

Contractors shall deny the CWF rejected G-code line when the claim has recycled three times without finding the associated drug J-code claim and use the following messages:

CARC 16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N657 - This should be billed with the appropriate code for these services. Claim Adjustment Group Code - CO (Contractual Obligation)

MSN message: 41.14: This service/item was billed incorrectly. 41.14- Este servicio o artículo fue facturado incorrectamente.

Contractors shall deny CWF rejected claims for more than one claim line service of G0088, G0089, or G0090 within a 60 day period and use the following messages:

CARC 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N640 - Exceeds number/frequency approved/allowed within time period.

Group Code - CO (Contractual Obligation)

411.6 – CWF and MCS Editing Requirements

(Rev. 10269, Issued: 08-07-2020, Effective: 01-01-2021, Implementation: 01-04-2021)

MCS shall create a new edit to identify when there is more than one of the following six HCPCS 'G0068', 'G0069' 'G0070', 'G0088', 'G0089', or 'G0090' with Date of Service on or after 1/1/2021 for the same Date of Service on the same Part B Professional claim.

CWF shall create a new reject for a Part B Professional claim with one of the following six HCPCS codes 'G0068', 'G0069' 'G0070', 'G0088', 'G0089', or 'G0090' with Date of Service on or after 1/1/2021 and there is no DME claim in history with one of the identified J-codes within 30 days prior to the incoming Date of Service.

***NOTE**: This edit shall have override capability at the claim detail line*

CWF and contractors shall recycle 'G0068', 'G0069' 'G0070', 'G0088', 'G0089', or 'G0090' claim up to three times for a total of 15 days until a claim containing an allowable drug J-code from above is received with the same line item date of service or within 30 days prior to the line item date of service of the G-code.

CWF shall create a new reject for a Part B Professional claim with one of the following six 'G0068', 'G0069' 'G0070', 'G0088', 'G0089', or 'G0090' codes with a Date of Service on or after 1/1/2021 when there is a Part B claim in history with one of the identified six 'G0068', 'G0069' 'G0070', 'G0088', 'G0089', or 'G0090' codes for the same Date of Service.

***NOTE**: This edit shall have override capability at the claim detail line*

CWF shall create a new reject for a Part B Professional claim with one of the new 'G0088', 'G0089', or 'G0090' codes and in history is an allowed DME or Part B Professional claim with any of the six 'G0068', 'G0069' 'G0070', 'G0088', 'G0089', or 'G0090' codes and the Dates of Service is within 60 days prior to the incoming claim's Dates of Service. The incoming claim has Dates of Service on or after 1/1/2021.

CWF should still subject an incoming Part B Professional claim to the edit if it is within 60 days of posted DME claim, and if the claim in history is DME and has one of the three existing 'G0068', 'G0069' 'G0070' codes and has Dates of Service prior to 1/1/2021.

CWF shall create a new Informational Unsolicited Response (IUR) when a Part B Professional claim or a DME claim with one of the six 'G0068', 'G0069' 'G0070', 'G0088', 'G0089', or 'G0090' codes is received and in history is a Part B Professional claim with one of the three new 'G0088', 'G0089', or 'G0090' codes with Dates of Service within 60 days after the incoming claim's Dates of Service.

CWF shall ensure that all new edits and the IUR appear on the ORPN Report.

Attachment A: Billing for Home Infusion Therapy Services on or After January 1, 2021

Table 1 shows the time increments providers should report visit length in 15-minute increments (15 minutes = 1 unit). See the table below for the rounding of units:

Table 1: Time Increments

Unit	Time
1	<23 minutes
2	= 23 minutes to <38 minutes
3	= 38 minutes to <53 minutes
4	= 53 minutes to <68 minutes
5	= 68 minutes to <83 minutes
6	= 83 minutes to <98 minutes
7	= 98 minutes to <113 minutes
8	= 113 minutes to <128 minutes
9	= 128 minutes to <143 minutes
10	= 143 minutes to <158 minutes

Table 2 shows the use of the three G-codes established for the home infusion therapy benefit, and reflects the therapy type and complexity of the drug administration.

Table 2: Payment Categories for Home Infusion Therapy Professional Services (G-Codes)

	Category 1	**Category 2**	**Category 3**
Description **G-Code**	Intravenous anti-infective, pain management, chelation, pulmonary hypertension, inotropic, and other certain intravenous infusion drugs	Subcutaneous immunotherapy and other certain Subcutaneous infusion drugs	Chemotherapy and other certain highly complex intravenous drugs
Initial Visit	G0088	G0089	G0090
Subsequent Visit	G0068	G0069	G0070

Table 3 provides a list of J-codes associated with the home infusion drugs that fall within each category.

Table 3: Payment Categories for Home Infusion Drugs (J-Codes)

Category 1	
J-Code	Description
J0133	Injection, acyclovir, 5 mg
J0285	Injection, amphotericin b, 50 mg

J0287	Injection, amphotericin b lipid complex, 10 mg
J0288	Injection, amphotericin b cholesteryl sulfate complex, 10 mg
J0289	Injection, amphotericin b liposome, 10 mg
J0895	Injection, deferoxamine mesylate, 500 mg
J1170	Injection, hydromorphone, up to 4 mg
J1250	Injection, dobutamine hydrochloride, per 250 mg
J1265	Injection, dopamine hcl, 40 mg
J1325	Injection, epoprostenol, 0.5 mg
J1455	Injection, foscarnet sodium, per 1000 mg
J1457	Injection, gallium nitrate, 1 mg
J1570	Injection, ganciclovir sodium, 500 mg
J2175	Injection, meperidine hydrochloride, per 100 mg
J2260	Injection, milrinone lactate, 5 mg
J2270	Injection, morphine sulfate, up to 10 mg
J3010	Injection, fentanyl citrate, 0.1 mg
J3285	Injection, treprostinil, 1 mg
Category 2	
J-Code	Description
J1555 JB	Injection, immune globulin (cuvitru), 100 mg
J1558 JB	Injection, immune globulin (xembify), 100mg
J1561 JB	Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g. liquid), 500 mg
J1562 JB	Injection, immune globulin (vivaglobin), 100 mg
J1569 JB	Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg
J1575 JB	Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immune globulin
Category 3	
J-Code	Description
J9000	Injection, doxorubicin hydrochloride, 10 mg
J9039	Injection, blinatumomab, 1 microgram
J9040	Injection, bleomycin sulfate, 15 units
J9065	Injection, cladribine, per 1 mg
J9100	Injection, cytarabine, 100 mg
J9190	Injection, fluorouracil, 500 mg
J9360	Injection, vinblastine sulfate, 1 mg
J9370	Injection, vincristine sulfate, 1 mg

The payment category may be determined by the DME MAC for any new home infusion drug additions to the Local Coverage Determination (LCD) for External Infusion Pumps as identified by the following not-otherwise-classified (NOC) codes:

J7799 - Not otherwise classified drugs, other than inhalation drugs, administered through DME
J7999 - Compounded drug, not otherwise classified.